BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: MICHAEL G. Claimant, vs. NORTH LOS ANGELES COUNTY REGIONAL CENTER, Service Agency.	OAH No. 2012090031

PROPOSED DECISION

This matter came on regularly for hearing on June 13 and September 12, 2013, in Santa Clarita, California, before H. Stuart Waxman, Administrative Law Judge, Office of Administrative Hearings, State of California.

Michael G.[1] (Claimant) was represented by Jeffrey A. Gottlieb, Attorney at Law.

North Los Angeles County Regional Center (Service Agency) was represented by Stella Dorian, Risk Assessment Supervisor.

Oral and documentary evidence was received. The record was held open to and including October 17, 2013, for the parties to submit briefs in accordance with a specified briefing schedule. Service Agency's Closing Argument was timely received and marked as Exhibit 43 for identification. Claimant's Closing Brief was timely received and marked as Exhibit GG for identification. Claimant's Closing [Rebuttal] Brief was timely received and marked as Exhibit HH for identification. A rebuttal brief from the Service Agency was not received. The record was closed on October 17, 2013, and the matter was submitted for decision.

[1] Initials are used in lieu of Claimant's surname and those of his relatives in order to protect their privacy.

ISSUE

The sole issue in this matter is whether Claimant is eligible for regional center services by virtue of a diagnosis of mental retardation, a condition similar to mental retardation, or one requiring treatment similar to that required for mentally retarded individuals .(The latter two criteria are known collectively as the "fifth category").

EVIDENCE CONSIDERED

1. Exhibits 1 through 42.
2. Exhibit A.
3. Exhibits C through K.
4. Exhibits S through FF.
5. Testimony of Heike Ballmaier, Psy.D.
6. Testimony of Veronica Campbell
7. Testimony of Susan Woods
8. Testimony of Mick Ryan
9. Testimony of Karen Davis
10. Testimony of Elenor G.

FACTUAL FINDINGS

Background Information

1. Claimant is a 23-year-old male with a long history of mental disorders. He has spent much of his life in out-of-home placements. He has attempted to harm himself on at least two occasions. He has engaged in violent behavior against others on numerous occasions. He has a history of socially immature and inappropriate behaviors including bullying lower functioning individuals and making crude and silly comments. He has had, and continues to have difficulty communicating his feelings. He has poor insight and problem-solving skills. Video games are his main source of enjoyment.

2. Over the past several years, Claimant has been diagnosed with numerous mental and developmental disorders including Major Depressive Disorder, Severe with Psychotic Features; Generalized Anxiety Disorder; Attention Deficit Hyperactivity Disorder (ADHD); Mixed Receptive/Expressive Language Disorder; Learning Disorder; Intermittent Explosive Disorder; Bipolar Disorder, rule out mental retardation; Pervasive Developmental Disorder Not Otherwise Specified; Obsessive Compulsive Disorder, with poor insight, atypical subtype with a personal and extended family history of compulsive hoarding syndrome manifested in aggressive and self-abusive themes; Oppositional Defiant Disorder; Reading Disorder, rule out Borderline Intellectual Functioning; Asperger's Disorder; Autistic Disorder; and Cognitive Disorder.

3. Claimant's IQ has been tested on numerous occasions. Results have ranged as follows:

Verbal IQ:	52-78
Performance IQ:	63-104[2]
Full Scale IQ:	54-77

Dr. Heike Ballmaier

4. Heike Ballmaier, Psy.D. is a psychologist employed by the Service Agency. Dr. Ballmaier explained that a critical difference exists in IQ test results for individuals with mental retardation as opposed to those with a learning disorder. Individuals with mental retardation tend to show global cognitive deficits with low scores in all areas of cognitive skills. Test results for individuals with learning disorders tend to show a scatter of skills with deficits in only a few areas. In addition, individuals with learning disorders tend to be higher functioning in adaptive areas than those with mental retardation.

5. Dr. Ballmaier also explained that individuals who fall into the fifth category of eligibility tend to have cognitive skills in the low borderline range (full scale IQ = 70-74) with substantial adaptive deficits that are linked to their cognitive skills. Treatment similar to that required for individuals with mental retardation includes intervention involving increasing adaptive functional and skill deficits. Such individuals need more practice and repetition than others. Therefore, the skills are broken down to their parts and are repeated until the individual can perform the skill repetitively, actively, and with increasing speed. An individual in the fifth category would likely require assistance with daily living skills, including hygiene, and typically could not maintain competitive employment. Therefore, such an individual would need employment services or be placed in a day program.

6. Dr. Ballmaier has not met or evaluated Claimant. She reviewed numerous reports from the various mental health care providers referenced below. She found that Claimant tended to score low in adaptive functioning and explained that individuals with mental retardation commonly score under the first percentile in adaptive functioning. His verbal skills are in the borderline deficit range. His non-verbal skills are in the average range. However, based on the reports she reviewed, she believes that Claimant has a learning disability and severe psychiatric problems, but that he does not have mental retardation or a condition that would qualify him for regional center supports and services under the fifth category of eligibility.

[2] Except for the one score of 104 on the Performance IQ scale, all scores were in the deficit, borderline or low average range.

The Tests

7. Claimant underwent a speech and neuropsycholinguistic evaluation at the UCLA Neuropsychiatric Hospital on February 5 and 6, 1997. He was six years, seven months old at that time. He was found to have a language learning disability, "characterized by impaired auditory processing abilities, poor problem solving and verbal reasoning skills, reduced semantic skills, and impaired pragmatics. Language skills ranged from a four to five year age level." (Exhibit 2.)

8. In an initial assessment in April 1999 by the Los Angeles County Department of Mental Health, for residential placement at The Sycamores, a Level 14 facility, Claimant was diagnosed with Major Expressive Disorder, Severe with Psychotic Features, Generalized Anxiety Disorder, and DHD. He was also found to have cognitive impairments including a long-standing expressive language disorder, difficulty with auditory processing, poor ability to abstract, and low frustration tolerance with tasks he thought were too difficult for him. (Exhibit 3.) Claimant resided at The Sycamores for approximately three years.

9. On December 10, 2000, at age 10, Claimant underwent a Psychological Evaluation through his school district. During the testing, he "began to leave his seat constantly and walk around the room or climb upon top of the table used for the testing and lay down very closely to the examiner's face and stare." (Exhibit 5.) He showed extremely low frustration tolerance and fear of failure in connection with even slightly challenging items. Verbal, Performance, and Full Scale IQ were 59, 66, and 60, respectively. However, the examiner did not believe those scores were a true representation of his intellectual ability, and he opined that his intellectual ability was actually in the low average to average range. The examiner determined that Claimant "is struggling to cope with severe ADHD and a bipolar disorder. All indications from this assessment show that his learning difficulties continue to be due to a serious emotional disturbance. His condition continues to warrant a placement where he can receive intensive residential and day treatment services." (*Id*.)

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10. In June 2002, at age 11, Claimant underwent a psychiatric assessment by Andrea Moskowitz, M.D., with Vista Del Mar Child and Family Services. Dr. Moskowitz described the history of presenting problems as follows:

> Michael has had behavioral difficulties and outbursts since preschool. He has a history of aggressive behavior including physical and verbal aggression, threatening to kill and hurt others, mood swings, oppositionality, refusal to do school work or stay in class, leaving classroom setting without permission, poor impulse control, poor social skills, and dangerous behavior. His dangerous behavior has included lighting papers on fire, playing with knives, trying to jump from a moving car, talking about flying, jumping from stairs, and walking into walls. He has a history of problems with attention and being extremely fidgety and impulsive. When he was about five years old he had to circle all the punctuation marks in magazines and he still seems to pay an inordinate amount of attention to punctuation. It should be noted that Michael's behavior has improved greatly since December of 2001. At that time, he was taken off of most of the medications that he had been on and was placed on a very low dose of Gabitrol. Since then although he still continues to have problems with leaving the classroom setting without permission he has had much less aggressive and dangerous behavior. His impulsivity has improved and his mother reports that he can communicate better and talk more about his feelings. At this time it is being recommended that he leaves Sycamore's because he is no longer in need of a level fourteen facility but is not able to go directly home.
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> Michael has had a variety of diagnoses most notably Bipolar Disorder. It has been reported that he has had manic episodes in October of 1996, January of 1997, August of 1998, and November of 2001. In October of 1996 he was very agitated and engaged in a lot of dangerous behavior including setting fires, playing with knives, trying to jump from a moving car, talking about trying to fly and jump from stairs, and walking into walls. In May of 1997 he struck his brother with a baseball bat and threatened his family with a steak knife. In August of 1998 he [had] homicidal thoughts towards his stepfather and younger brother and reportedly had difficulties sleeping and organizing his thoughts. Reportedly the first two manic episodes were triggered by being on antidepressants and besides his aggressive behaviors he was extremely agitated, hypersexual and had decreased sleep and appetite. The last manic episode was triggered by his rapidly being taken off all his current medications. All of the episodes abated very quickly when he was contained in a hospital setting. In the past he also has a history of suicidal ideation without intent. Michael has a history of extremely poor social skills and difficulties interacting at all appropriately with peers and family members.

(Exhibit 8.)

11. Dr. Moskowitz diagnosed Claimant with ADHD, Bipolar Disorder, and Learning Disorder, with rule out diagnoses of Mental Retardation and Pervasive Developmental Disorder, Not Otherwise Specified.

12. On December 9, 2003, Dr. Moskowitz noted that:

> Michael's developmental history was significant for delays in language with first words not being spoken until two years of age and sentences not being spoken until two and a half to three years of age. As a toddler he was very sensitive to clothing textures and would pull out his hair and chew on clothing. He also seemed to be overly sensitive to pain and to sudden loud noises. There is a history of head banging at night. He has had difficulties with both gross and fine motor skills and was not able to ride a bicycle without training wheels until the age of 11. There is a history of fire setting and a history of hurting animals.

(Exhibit 9.)

13. Dr. Moskowitz went on to write that Claimant continued to be "very concrete," and that he acted inappropriately with classmates. Dr. Moskowitz discontinued the Gabitrol and prescribed Modafanil. She added Autistic Disorder to his list of diagnoses. (*Id.*) However, no evidence was offered to show that her new diagnosis was based on objective testing.

14. Between October 2002 and January 2003, Claimant, who was then 12 years old, underwent an extensive psycho-educational evaluation by Joanne Royer, Ph.D., at Reiss-Davis Child Study Center. At the conclusion of the evaluation, Dr. Royer ruled out mental retardation, Autism, and Asperger's Disorder. She diagnosed him with Dysthymia, Oppositional Defiant Disorder, Learning Disorder Not Otherwise Specified, Reading Disorder, and Borderline Intellectual Functioning, with a rule out diagnosis of Pervasive Developmental Disorder. (Exhibit C.)

15. Dr. Ballmaier opined that, because Claimant had been very uncooperative during the testing,[3] the results of Dr. Royer's testing must be evaluated with caution because Claimant's lack of cooperation and his negative conduct may have affected the test results. However, the examiner found the test to be a valid representation of Claimant's intellectual function because there was no significant discrepancy between his verbal IQ of 78 and his performance IQ of 73.

16. Claimant remained a resident of Vista Del Mar, a Level 12 facility, from approximately May 2002 to February 2004.

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[3] Claimant walked out of the first two sessions and almost walked out of the third. He was sarcastic and caustic with the evaluator. It was necessary to establish an award system just to keep Claimant involved in the process.

17. In a Social Assessment by the Service Agency dated September 2, 2004, Claimant was found capable of attending to all of his self-care needs independently. He could perform multi-digit addition and subtraction with prompting and knew some simple multiplication facts. He could read simple sentences. He knew part of his address. He had difficulty discerning social cues and had a lack of social skills. He had difficulty adapting to change and was quick to anger. He did better when following a routine. Despite the finding that Claimant could attend to all of his self-care needs, the evaluator found he exhibited deficits in the areas of self-care, learning and self-direction. (Exhibit 13.)

18. In August 2008, Claimant was accepted as a resident at Devereux Victoria with diagnoses of Obsessive Compulsive Disorder with poor insight, atypical subtype with a personal and extended family history of compulsive hoarding syndrome manifested in aggressive and self-abusive themes; Oppositional Defiant Disorder, by history; and Learning Disorder, mixed, by history. His estimated length of stay was six to nine months. (Exhibit 14.)

19. On January 18 and 19, 2009, at age 18, Claimant underwent a psychological evaluation by Karan Redus, Ph.D. (Exhibit 15.) The evaluation was spread over two days due to Claimant's frustration level and his decreased ability to remain on task. Dr. Radus considered the testing to be a "valid indication of his current day to day intellectual and behavioral/emotional functioning," but that his inconsistent motivation could have resulted in test scores that under-estimated his true optimum level of functioning.

20. Test results showed overall intellectual ability at 69 (very low range), verbal ability at 73 (low range), and intentional cognitive processing at 84 (low average range). He scored in the following ranges on the Behavior Assessment for Children-2 (self rating):

Category	**Range**
Attitude to School	Clinically Significant
Attitude to Teachers	At-Risk
Interpersonal Relations	Clinically Significant
Hyperactivity	At-Risk
Anger Control	At-Risk

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21. The teaching staff at Claimant's school completed the Behavior Assessment System for Children-2 (teacher rating). Claimant scored in the following ranges on that instrument:

Category	**Range**
Aggression and Conduct Problems	Clinically Significant
Anger Control	Clinically Significant
Bullying	At-Risk
Depression	Clinically Significant
Atypicality	Clinically Significant
Withdrawal	At-Risk
Attention Problems	At-Risk
Adaptability	At-Risk
Social Skills	At-Risk
Developmental Social Disorders	At-Risk
Study Skills	At-Risk
Executive Functioning	Clinically Significant
Negative Emotionality	Clinically Significant
Self-Control	At-Risk

22. Dr. Redus went on to write: "Additional rating of his adaptive behavior skills completed by his direct care staff suggested that his adaptive skills were generally below average across all but one skill area. Two of his skills are . . . significantly below average (Communication and Health and Safety). (*Id.*)

23. Dr. Redus diagnosed Claimant with Obsessive-Compulsive Disorder, Oppositional Defiant Disorder, and Learning Disorder, not otherwise specified, with a rule out diagnosis of Borderline Intellectual Functioning. She summarized her findings as follows:

> Michael was an 18 year old male who was functioning in the very low range of cognitive abilities at the time of testing. His difficulty remaining on task and low frustration tolerance raised the question as to whether his current scores might under-estimate his true optimum level of functioning. On academic achievement testing, scores on Math Calculation and Oral Language were significantly below the range expected given his overall, general intellectual abilities, and appeared to be consistent with his earlier diagnosis of learning disorder.

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> Michael presented as being [a] withdrawn, irritable individual who displayed a low tolerance for frustration and difficulty completing tasks that required . . . maintaining attention and effort. Behavior ratings indicated that he was reporting difficulty with restless, disruptive behavior and difficulty controlling his anger. Behavior ratings from his staff suggested that he displayed problems with disruptive, restless, defiant behaviors, and tends to be withdrawn and pessimistic. These ratings also suggested that he may tend to have problems maintaining his behavior and mood and may tend to react negatively to changes in his everyday activities. (*Id.*)

24. On June 11, 2010, at age 20, Claimant underwent another social assessment by the Service Agency. The evaluator recorded the descriptions of Claimant and his mother with respect to his self-care and cognitive skills as follows:

> **Self-Care:**
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> Michael reports that he takes care of his self-care needs. He and his mother report that he needs reminding to do these things. His mother reports that Michael needs to do a better job of cleaning his teeth, because he recently had to have dental work done to fill cavities. Michael stated, "Sometimes I forget." Michael reports that he is able to make a sandwich and cook simple things on the stove, but he doesn't get much opportunity to do so at his current placement. He reports that he knows how to use the microwave oven. He reports that he has chores at his facility. He vacuums, sweeps and mops the floors. He reports that he often forgets to do his chores and the staff remind him. He reports that he has never taken public transportation independently. He has never had a driver's license. He reports that this is something he would like to do in the future. Michael reports that he usually spends his money on video games. He reports that he likes the violent games. He reports that he is able to make purchases independently, but he doesn't get a lot of opportunities to do so. He reports that he usually knows approximately how much change to get back from a purchase, and he knows when someone is "ripping him off." His mother reports that Michael is somewhat impulsive regarding his money. He has a hard time saving money. He has never had a checking account.
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> **Cognitive:**
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> Michael is able to read. He and his mother report that Michael has trouble putting his thoughts on paper. He is not good at writing paragraphs. He reports that he . . . doesn't have access to a computer at his placement. He reports that he doesn't like to e-mail anyway. He is not able to tell time on an analog clock. He reports that he has trouble with algebra and geometry at school. He knows the days of the week and months of the year.

(Exhibit 20.)

25. On July 14, 2010, approximately one month after the Service Agency's social assessment, Claimant underwent a psychological evaluation by Kathy Khoie, Ph.D. (Exhibit 21.) On the Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV), Claimant's verbal IQ was 74 and his performance IQ was 96. Dr. Kohie did not calculate a full scale IQ because of wide gaps between indices.

26. On the Adaptive Behavior Assessment System, Second Edition (ABAS-II), Claimant scored in the deficit range in the following categories: Community Use, Functional Academics, Home Living, Health and Safety, Leisure, Self-Care, Self-Direction, and Social. Dr. Khoie explained:

> Overall, on the ABAS-II, Michael obtained a standard score of 42 on the General Adaptive Composite. His true score is likely to fall within the range of 40 to 44 at a 90% level of confidence. Relative to individuals of comparable age, Michael currently is functioning at .1 percentile and his overall adaptive behavior can be described as being in the deficit range of functioning. Parental report on ABAS-II appeared inconsistent with the examination results and the examiner's observations.

27. Dr. Khoie opined that Claimant did not meet the diagnostic criteria for mental retardation. Although she did not calculate a full-scale IQ, she explained that his cognitive functioning could be better understood through a subtest analysis. The subtest scores ranged from the deficit range to borderline range with matrix reasoning in the average range. Dr. Khoie estimated Claimant's overall cognitive functioning to be in the low average to average range.

28. Dr. Ballmaier testified that, at the time of Dr. Khoie's evaluation, Claimant was in a residential treatment facility and had been in such facilities from age 9 to 20. She opined that individuals in residential treatment facilities do not receive as much exposure to developing adaptive functioning as those who live at home and have responsibilities. That testimony was not convincing in that it failed to take into account the responsibilities placed on individuals in residential facilities as part of their treatment and development, and it failed to take into account individuals who grow up at home in an environment in which little burden is placed on them to accept responsibilities and obligations, and those who simply reject them without serious consequences.

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29. On September 20 and October 4, 2011, Claimant underwent a psychological evaluation by Mary Ann Gansle, Ph.D. Following a clinical interview, review of records, interview with staff, and the administration of several psychometric tests, Dr. Gansle diagnosed claimant with Cognitive Disorder, Bipolar Disorder Not Otherwise Specified (by history), Oppositional Defiant Disorder (by history), Asperger's Disorder (by history), and Learning Disorder, Not Otherwise Specified (by history). Dr. Gansle summarized her findings as follows:

> Michael presents with inconsistencies across skills in both cognitive abilities and executive functioning skills. Intellectual assessment yielded low range functioning with a significant relative strength noted in visual spatial tasks. This strength was also noted in executive functioning tasks measured by the DKEFS [Delis-Kaplan Executive Function System]. Michael's adaptive behavior skills were in the low range, commensurate with his overall intellectual skills.
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> It is believed that, due to index score discrepancies on the WAIS-IV, the full scale IQ score cannot be considered an accurate measure of Michael's intellectual abilities. Three out of 4 index scores fell in the low range, which appear to represent Michael's approximate level of functioning, especially when compared to his adaptive behavior skills, as measured by the Vineland Adaptive Behavior Scales, 2nd edition, which are also in the low range.
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> Michael's performance on the DKERS, which measures executive functioning abilities, indicates a commensurate strength in visual spatial skills, with weaknesses noted in problem solving, cognitive flexibility, reasoning abilities, and verbal fluency. When examining the pattern of scores on the DKERS, patterns such as Michael's are influenced by frontal lobe functioning, as well as conditions such as depression, obsessive compulsive tendencies, traumatic brain injury, anxiety, medication, and other related symptomatology. Due to the presence of several influencing factors, it cannot be determined what degree of influence each factor had on Michael's performance on this test. It is apparent, however, that many of his scores were well below his age level, indicating a significant deficit in executive functioning, which are skills necessary for independent functioning. Michael's pattern of skill deficits along with the inconsistent splinter skills suggest the presence of cognitive impairment of some kind, specifically Cognitive Disorder, NOS.

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> Additionally, Michael continues to present with symptoms of Bipolar Disorder, which appear to be controlled with recent medication changes. Episodes of rage and intense anger have recently reduced in frequency due to these changes. Symptoms of depression continue to influence his daily functioning. He continues to display characteristics associated with Asperger's Disorder, including a qualitative impairment in social interaction and restricted range of interests and activities. Specifically, Michael exhibits a marked impairment in the use of nonverbal behaviors used to regulate social interaction, a failure to develop peer relationships to an age appropriate level, a lack of spontaneous seeking to share enjoyment, and a lack of emotional reciprocity. Additionally, he exhibits an adherence to nonfunctional routines or rituals, often repetitive in nature. He also exhibits anxiety symptoms often present in those with Asperger's Disorder.

(Exhibit 22.)

30. On April 22 and 26, 2013, Karen Schlitz, Ph.D. performed a neuropsychological assessment on Claimant. Her test, using the WAIS-IV, revealed a full scale IQ of 77 (borderline range). Dr. Schlitz's report does not address the sub-tests or scatter within them, and it does not reference any other testing. (Exhibit U.) For those reasons, Dr. Schlitz's report is given little weight.

31. Claimant passed the California High School Exit Exam (CAHSEE) on November 3, 2009, after two previous failed attempts. He required and was provided special accommodations for his third attempt.

Veronica Campbell

32. Veronica Campbell is a Marriage and Family Therapist who treated Claimant for approximately six months in 2012 when he was 22 years old. Her involvement with Claimant was to assist him in his activities of daily life. She assisted him in taking his medication on time, cooking, shopping, budgeting and transportation. Claimant was unable to find his way to a bus stop or take a familiar bus route by himself. His cooking skills were limited to heating a burrito. Claimant was living alone with a cat during his treatment with Ms. Campbell. He had poor hygiene, and his home smelled of cat feces and urine. He was given both oral and written instructions several times concerning his activities of daily living, but he was unable to follow through with them. Ms. Campbell attempted to engage Claimant and motivate him. She taught him activities in small steps. However, although he was more interested in certain areas over others, he made no progress in any area. Ms. Campbell found that Claimant was not successful in living on his own.

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Dr. Mick Ryan

33. Mick Ryan treated Claimant for approximately three years beginning in 1999 at Hathaway-Sycamores Childhood Family Services, a residential treatment facility. He found that Claimant had deficits in self-help/self-care, hygiene, following simple directions, and forming peer relationships. He was unable to shower on his own, and he needed reminders of what he should be doing.

Karen Davis

34. Karen Davis has been a physician's assistant for 28 years and is Claimant's present health care provider. She testified to Claimant's cognitive abilities stating that he has deficits in carrying out tasks such as preparing meals, going to the store, and other tasks that require several steps. He has a limited ability to understand his medication schedule, and safety issues in the bathroom and kitchen. He requires structure, supervision, and prompting including visual prompting, and he needs immediate feedback on tasks he attempts. He is verbal but does not always understand what is said to him. Ms. Davis does not believe Claimant can obtain or maintain employment based on his mental and cognitive issues, and she does not believe he is able to live on his own because of safety concerns and self-care deficits. Ms. Davis opined that Claimant has unique cognitive disabilities separate from his mental health issues.

Elenor G.

35. Throughout his life, the person with whom Claimant has been most close is his mother, Elenor G. Ms. G. testified at the hearing, providing a description of Claimant's cognitive deficits.

36. Claimant presently takes approximately six psychotropic medications, and did so before he reached the age of 18. He needs reminders to take his medication because he does not always remember to do so. He is able to shower but does so inconsistently unless prompted. He has body odor as a function of his poor hygiene. He does not know to change his clothes every day and often wears dirty clothes. When he is reminded to change his clothes, he gets a "deer in the headlights look" (Ms. G's term). He is unable to go to the barber by himself.

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37. When Claimant lived alone, Ms. G. regularly went to his home to tell him what he needed to do. She stopped that practice at a therapist's recommendation to see if Claimant could live on his own. Ms. G. explained "everything fell apart." There was unwrapped food in the refrigerator. Claimant had to go to an emergency room because he ate undercooked food. He put dishes away with food on them. His hygiene was poor. He did not clean the cat litter box. Ms. G. began going to Claimant's home once per week, and she worked with him on "cleaning day." She tried to make it fun by giving them each a task. She also called him each day to ask what he had done on his list for that day. Claimant is able to communicate with family because his mother gave him photographs of family members bearing their respective telephone numbers. Claimant did not always follow through on tasks. For example, he put clothes in the washer but not in the dryer. He put a toothbrush and toothpaste in the shower to remind him to brush his teeth when he showered. He is no longer able to do that because he shares a bathroom with others. As a result, he now needs extensive dental work. He sometimes indicates that he understood something when, in fact, he did not. He does not set goals, understand social cues, or understand body boundaries. Claimant has not experienced any significant progress in any cognitive area over time.

38. Claimant presently lives in a residential care facility. Staff members instruct him to put his dirty clothes in a basket, but if the basket is moved, he does not think to find it. He then believes he has no clothes.

39. Claimant is able to learn multi-step tasks if the tasks are broken down and learned in a structured, step-by-step manner. He can ride a bicycle but must be repeatedly told the safety rules. He did not begin to ride a bicycle until he was 14 years old.

40. Ms. G. opined that Claimant is incapable of getting a job on his own. He attempted to work, but he was unable to explain to his employer what he needed. He "shut down" (Ms. G.'s term) because he was unable to communicate. That was a result of his receptive communication skills which Ms. G. described as "awful." He does not understand what people are saying, and he has difficulty saying what he wants to say. However, he is able to text his mother.

41. Particularly compelling was Ms. G.'s testimony regarding a trip Claimant took from his residential facility to visit his family in the Los Angeles area. Due to his deficits, it was pre-arranged that Claimant would be placed on a non-stop flight. He missed that flight, and the individual charged with seeing him off placed him on a flight with a lay-over in San Jose. When Claimant arrived in San Jose, he was unable to determine what to do, and he did not know to go to the gate for the connecting flight or how to get there. He was placed on stand-by on two flights but did not know what stand-by meant and therefore missed both flights. As a result, he "curled up" (Ms. G.'s term) in the baggage claim overnight. Neither his family nor the staff at the residential facility could locate him, a situation Ms. G. described as "horrific." Ms. G. convincingly summed up the experience by saying, "That's not mental health, that's cognitive. He can't connect the dots."

LEGAL CONCLUSIONS

1. Claimant has established that he suffers from a developmental disability entitling him to regional center services. (Factual Findings 1 through 41.)

Witness Credibility

2. The law is clear as to the weight to be given the testimony of the expert witnesses in this matter. Greater weight is given to the experts who personally treated and/or evaluated Claimant and wrote reports than the testimony of Dr. Ballmaier who only conducted a record review and who has never met or evaluated Claimant. In *People v. Bassett* (1968) 69 Cal.2d 122, the Court analyzed the use of expert testimony when the issue is one of mental competence. The Court stated, commencing at page 141:

> Mental illnesses are of many sorts and have many characteristics. They, like physical illnesses, are the subject matter of medical science. They differ widely in origin, in characteristics, and in their effects on a person's mental processes, his abilities, and his behavior. . . . Description and explanation of the origin, development and manifestations of the alleged disease are the chief functions of the expert witness. The chief value of an expert's testimony in this field, as in all other fields, rests upon the material from which his opinion is fashioned and the reasoning by which he progresses from his material to his conclusion; in the explanation of the disease and its dynamics, that is, how it occurred, developed and affected the mental and emotional processes . . . it does not lie in his mere expression of conclusion . . .both [doctors who testified for the State] conceded on the stand that they had never talked with this defendant, and the record does not disclose they had ever seen him . . . [A] distinguished federal court recently surveyed the medical writings on this subject, and concluded, "The basic tool of psychiatric study remains the personal interview, which requires rapport between the interviewer and the subject . . ." [The doctors for the state] left no doubt on cross-examination that their regular practice was to conduct personal examinations and that they would have preferred to do so in this case.

3. The *Bassett* Court gave little weight to the testimony of the experts who had not examined the defendant, but only conducted a record review. In contrast, the Court gave substantial weight to the evidence presented by the defendant's experts who thoroughly examined, tested and interviewed the defendant. For these reasons, Dr. Ballmaier's expert testimony is given less weight than the reports of Claimant's health care providers and evaluators.

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The Applicable Law

4. Throughout the applicable statutes and regulations (Welf. & Inst. Code, §§ 4700 - 4716, and Cal. Code Regs., tit. 17, §§ 50900 - 50964), the state level fair hearing is referred to as an appeal of the regional center's decision. A claimant seeking to establish eligibility for services bears the burden of proving the Service Agency's decision is incorrect. Claimant has met his burden of proof in this case.

5. In order to be eligible for regional center services, a claimant must have a qualifying developmental disability. Welfare and Institutions Code section 4512, subdivision (a), defines "developmental disability" as:

> a disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual, and includes mental retardation, cerebral palsy, epilepsy, autism, and disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but shall not include other handicapping conditions that are solely physical in nature.

6. To prove the existence of a developmental disability within the meaning of Welfare and Institutions Code section 4512, a claimant must establish that he/she has a "substantial disability."

7. California Code of Regulations, title 17 (CCR), section 54001 defines "substantial disability" as:

> (1) A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and
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> (2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:
> (A) Receptive and expressive language;
> (B) Learning;
> (C) Self-care;
> (D) Mobility;
> (E) Self-direction;
> (F) Capacity for independent living;
> (G) Economic self-sufficiency.

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8. In addition to proving a "substantial disability," a claimant must show that his/her disability fits into one of the five categories of eligibility set forth in Welfare and Institutions Code section 4512. The first four categories are specified as: mental retardation, epilepsy, autism and cerebral palsy. The fifth and last category of eligibility is listed as "Disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation." (Welf. & Inst. Code, § 4512.) That category is not further defined by statute or regulation.

9. Unlike the first four categories of eligibility, which are specific, the disabling conditions under the fifth category are intentionally broad enough to encompass unspecified conditions and disorders. However, that broad language is not intended to be a catchall that entitles all persons with a learning or behavioral disability to regional center supports and services. The Lanterman Developmental Disabilities Services Act (Welf. & Inst. Code § 4500, et seq) does not impose on a regional center a duty to serve all such individuals.

10. While the Legislature has not defined the fifth category, it does require that the qualifying condition be "closely related" (Welf. & Inst. Code, § 4512, subd. (a)) or "similar" (Cal. Code. Regs., tit. 17, § 54000) to mental retardation or "require treatment similar to that required for mentally retarded individuals." (Welf. & Inst. Code, § 4512, subd. (a).) The definitive characteristics of mental retardation include a significant degree of cognitive and adaptive deficits. Thus, to be "closely related" or "similar" to mental retardation, there must be a manifestation of cognitive or adaptive deficits, or both, which render that individual's disability like that of a person with mental retardation. However, this does not require strict replication of all of the cognitive and adaptive criteria typically utilized when establishing eligibility due to mental retardation (e.g., reliance on IQ scores). If this were so, the fifth category would be redundant. Eligibility under this category requires an analysis of the quality of a claimant's cognitive and adaptive functioning and a determination of whether the effect on his performance renders him like a person with mental retardation. Furthermore, determining whether a claimant's condition "requires treatment similar to that required for mentally retarded individuals" is not a simple exercise of enumerating the services provided and finding that a claimant would benefit from them. The criterion is not whether someone would benefit. Rather, it is whether someone's condition <u>requires</u> such treatment.

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11. In *Mason v. Office of Administrative Hearings* (2001) 89 Cal.App.4th 1119, 1129, the Court stated:

> [S]ection 4512(a) is sufficiently precise, when considered in conjunction with the entire provision defining "developmental disability" and the implementing regulations, which provide additional guidance on what is considered a developmental disorder. Determination of developmental disability under the fifth category does not depend on a completely subjective standard. It does not contain a broad invitation to subjective or discriminatory enforcement. Rather, it requires a determination as to whether an individual's condition is substantially similar to that of mental retardation. And "[t]he term 'mental retardation' has a 'demonstrably established technical meaning' [citation] which basic definition remains well recognized [citation]; the term is not unconstitutionally vague." (Footnotes omitted.) *Money v. Krall, supra*, 128 Cal.App.3d 378, 398–399, 180 Cal.Rptr. 376.

12. In order to establish eligibility, a claimant's substantial disability must not be solely caused by an excluded condition. The statutory and regulatory definitions of "developmental disability" (Welf. & Inst. Code, § 4512 and Cal. Code. Regs., tit. 17, § 54000) exclude conditions that are solely physical in nature. California Code of Regulations, title 17, section 54000, also excludes conditions that are solely psychiatric disorders or solely learning disabilities. Therefore, a person with a "dual diagnosis," that is, a developmental disability coupled with a psychiatric disorder, a physical disorder, or a learning disability, can still be eligible for services. However, someone whose conditions originate only from the excluded categories (psychiatric disorder, physical disorder, or learning disability, alone or in some combination) and who does not have a developmental disability, will not be eligible.

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Mental Retardation and Borderline Intellectual Functioning

13. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revised (DSM-IV-TR)[4] describes mental retardation as follows:

> The essential feature of Mental Retardation is significantly subaverage general intellectual functioning (Criterion A) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety (Criterion B). The onset must occur before age 18 years (Criterion C). Mental Retardation has many different etiologies and may be seen as a final common pathway of various pathological processes that affect the functioning of the central nervous system.
>
> *General intellectual functioning* is defined by the intelligence quotient (IQ or IQ-equivalent) obtained by assessment with one or more of the standardized, individually administered intelligence tests (e.g., Wechsler Intelligence Scales for Children—Revised, Stanford-Binet, Kaufman Assessment Battery for Children). Significantly subaverage intellectual functioning is defined as an IQ of about 70 or below (approximately 2 standard deviations below the mean). It should be noted that there is a measurement error of approximately 5 points in assessing IQ, although this may vary from instrument to instrument (e.g., a Wechsler IQ of 70 is considered to represent a range of 65-75). Thus, it is possible to diagnose Mental Retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior. Conversely, Mental Retardation would not be diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairments in adaptive functioning. . . . When there is significant scatter in the subtest scores, the profile of strengths and weaknesses, rather than the mathematically derived full-scale IQ, will more accurately reflect the person's learning abilities. When there is a marked discrepancy across verbal and performance scores, averaging to obtain a full-scale IQ score can be misleading.

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[4] The Diagnostic and Statistical Manual of Mental Disorders (4th edition, Text Revision, 2000, American Psychiatric Association, also known as DSM-IV-TR) is a well-respected and generally accepted manual listing the diagnostic criteria and discussing the identifying factors of most known mental disorders. The manual uses a number system for the different disorders which is accepted by most medical and psychotherapeutic professionals (and insurance companies) as a shorthand method to designate the disorders that are more specifically described in the manual.

> Impairments in adaptive functioning, rather than a low IQ are usually the presenting symptoms in individuals with Mental Retardation. *Adaptive functioning* refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting. Adaptive functioning may be influenced by various factors, including education, motivation, personality characteristics, social and vocational opportunities, and the mental disorders and general medical conditions that may coexist with Mental Retardation. Problems in adaptation are more likely to improve with remedial efforts than is the cognitive IQ, which tends to remain a more stable attribute.

(DSM-IV-TR at pp. 39 - 42.)

14. Regarding mild mental retardation (IQ level of 50-55 to approximately 70), the DSM-IV-TR states:

> [Persons with mild Mental Retardation] typically develop social and communication skills during the preschool years (ages 0-5 years), have minimal impairment in sensorimotor areas, and often are not distinguishable from children without Mental Retardation until a later age. By their late teens, they can acquire academic skills up to approximately the sixth-grade level. By their adult years, they usually achieve social and vocational skills adequate for minimum self-support, but may need supervision, guidance, and assistance, especially when under unusual social or economic stress. With appropriate supports, individuals with Mild Mental Retardation can usually live successfully in the community, either independently or in supervised settings.

(*Id*. at pp. 42 - 43.)

15. Regarding the differential diagnosis of Borderline Intellectual Functioning (IQ level generally 71 to 84), the DSM-IV-TR states:

> Borderline Intellectual Functioning describes an IQ range that is higher than that for Mental Retardation (generally 71-84). As discussed earlier, an IQ score may involve a measurement error of approximately 5 points, depending on the testing instrument. Thus, it is possible to diagnose Mental Retardation in individuals with IQ scores between 71 and 75 if they have significant deficits in adaptive behavior that meet the criteria for Mental Retardation. Differentiating Mild Mental Retardation from Borderline Intellectual Functioning requires careful consideration of all available information.

(*Id*. at p. 48.)

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16. IQ is a statistical concept, derived by psychological testing. Mental retardation has been defined as two standard deviations below the mean, (the lower two to three percentile ranges of the population). With an average or mean IQ score being 100 and with a standard deviation being 15, an IQ score of 70 falls within the mentally retarded range, as long as the other criteria are met. But, as set forth in the DSM-IV TR, there is no such thing as an absolute IQ score. The "margin of error" can be as much as five points.

Claimant's Eligibility Under the Fifth Category

17. Claimant's intellectual functioning cannot be determined with complete specificity, but he does not appear to suffer from mental retardation. His various IQ tests have placed him in the range of mild mental retardation to borderline intelligence and, in one instance, average. However, as noted above, IQ alone does not determine whether an individual is mentally retarded. One must also look at the Claimant's adaptive functioning. As set forth in CCR section 54001, subdivision (b), because an individual's cognitive and/or social functioning are many-faceted, there are at least seven categories relative to adaptive functioning that must be examined. These categories are the same or similar to the categories of adaptive functioning skills listed in the DSM-IV-TR that, to support a diagnosis of mental retardation, requires a finding of significant limitations in at least two such skills. Applying the evidence, including but not limited to the various reports, the testimony of Claimant's treating health care providers, and the compelling testimony of Claimant's mother, to the seven listed categories reveals the following:

(1) Communication skills: Claimant is verbal, but at times, he is unable to understand what is being said to him.

(2) Learning: The evidence shows Claimant is severely impaired in his ability to learn.

(3) Self-care: Claimant's ability to take care of himself is significantly impaired.

(4) Mobility: Claimant's mobility is impaired in that, at 23 years old, he cannot access public transportation independently.

(5) Self-direction: Claimant has no self-direction, and cannot plan, organize or accomplish even simple tasks without direction, prompting and supervision.

(6) Capacity for independent living: Claimant cannot live independently.

(7) Economic self-sufficiency: There was no evidence that Claimant has any skills or abilities to perform any marketable service.

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18. It was established that Claimant has, at best, borderline intelligence and he also has major impairments in adaptive functioning. The range of Claimant's IQ scores, straddled by their margins of error, and coupled with his several and severe adaptive deficits, establish that Claimant suffers from a condition that is similar to mental retardation and is eligible for regional center supports and services under the fifth category.

19. Undeniably, Claimant has a variety of mental conditions. However, those conditions do not preclude a finding of regional center eligibility. His developmental disability is a co-morbid condition to his mental disorders.

20. The Association of Regional Center Agencies (ARCA) has published a set of proposed guidelines to be used by regional centers in determining eligibility under the fifth category.[5] Even though the guidelines are only proposed and would not be binding even if approved and operative, a review of the guidelines for an individual with a condition similar to mental retardation corroborates the finding that Claimant falls within that category. The guidelines state in relevant part:

> An individual can be considered to be functioning in a manner that is similar to a person with mental retardation if:
>
> > A. The general intellectual functioning is in the low borderline range of intelligence (IQ scores ranging from 70-74). Factors that the eligibility team should consider include:
> >
> > 1. Cognitive skills as defined in the California Code of Regulations, Title 17, Section 54002: " . . . the ability of an individual to solve problems with insight, to adapt to new situations, to think abstractly and to profit from experience."
> >
> > 2. The higher an individual's IQ is above 70, then the less similar to a person with mental retardation is the individual likely to appear. For example, an individual with an IQ of 79 is more similar to a person with low average intelligence and more dissimilar to a person with mild mental retardation.
> >
> > 3. As an individual's intelligence quotient rises above 70, it becomes increasingly essential for the eligibility team to demonstrate that:
> > a. there are substantial adaptive deficits, and
> > b. such substantial adaptive deficits are clearly related to cognitive limitations.

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[5] Association of Regional Center Agencies Proposed Guidelines for Determining "5th Category" Eligibility for the California Regional Centers (Guidelines).

4. Occasionally, an individual's Full Scale IQ is in the low borderline range (IQ 70-74) but there is a significant difference between cognitive skills. For example, the Verbal IQ may be significantly different than the Performance IQ. When the higher of these scores is in the low average range (IQ 85 or above), it is more difficult to describe the individual's general intellectual functioning as being similar to that of a person with mental retardation. In some cases, these individuals may be considered to function more like persons with learning disabilities than persons with mental retardation.

5. Borderline intellectual functioning needs to show stability over time. Young children may not yet demonstrate consistent rates and patterns of development. For this reason, eligibility for young children in the 5th category should be viewed with great caution.

B. In addition to sub-average intellectual functioning the person also must demonstrate significant deficits in *Adaptive* skills including, but not limited to, communication, learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency. Factors that the eligibility team should consider include:

1. Adaptive behavior deficits as established on the basis of clinical judgments supplemented by formal Adaptive Behavior Scales (e.g., Vineland, ABS, AAMR-ABS) when necessary.

2. Adaptive deficits are skill deficits related to intellectual limitations that are expressed by an inability to perform essential tasks within adaptive domains or by an inability to perform those tasks with adequate judgment.

3. Skill deficits are not performance deficits due to factors such as physical limitations, psychiatric conditions, socio-cultural deprivation, poor motivation, substance abuse, or limited experience.

(Exhibit 31.)

21. Based on the evidence presented, Claimant has met his burden of proof that he has a substantial disability as defined by Welfare and Institutions Code section 4512, and California Code of Regulations, title 17, section 54001 in that he has a condition similar to mental retardation.

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ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

The North Los Angeles County Regional Center's determination that Claimant is not eligible for regional center services is overruled, and Claimant's appeal of that determination is granted. The North Los Angeles County Regional Center shall accept Claimant as a client forthwith.

DATED: October 25, 2013

_____/s/_____
H. STUART WAXMAN
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision. Both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.